

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13614

CERTIFICATE OF DEATH

13605

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>1 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>Chesapeake City 3rd St.</u>			
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>W.</u> Last <u>BEISWANGER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Stationery store</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Beiswanger</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Weber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>097-03-8078</u>			
				17. INFORMANT Address <u>Mrs. Fred Beiswanger, Chesapeake</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardiac arrhythmia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 <u>58</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 18, 1958</u> to <u>Dec 18, 1958</u> , that I last saw the deceased alive on <u>Dec 18, 1958</u> , and that death occurred at <u>6:58 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Davis M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesapeake City Md</u>			
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>				DATE SIGNED <u>12/18/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bethel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter du Bose, Jr.</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>	
<p>4. DATE OF DEATH [Handwritten: Jan 15, 1950]</p>		<p>5. TIME OF DEATH [Handwritten: 10:00 AM]</p>		<p>6. PLACE OF DEATH [Handwritten: Home]</p>	
<p>7. OCCUPATION [Handwritten: Teacher]</p>		<p>8. MARITAL STATUS [Handwritten: Married]</p>		<p>9. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>	
<p>10. CAUSE OF DEATH [Handwritten: Heart Disease]</p>		<p>11. MANNER OF DEATH [Handwritten: Natural]</p>		<p>12. SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]</p>	
<p>13. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]</p>		<p>14. SIGNATURE OF WITNESS [Handwritten: J. Doe]</p>		<p>15. SIGNATURE OF DECEASED [Handwritten: John Doe]</p>	

13628 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
f. STREET ADDRESS 1427 Irving Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEWIS Middle M. Last BIVINS		4. DATE OF DEATH Month December Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1912
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR: Months 46 Days 46 Hours 46 Min. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Postal	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry C. Bivins		14. MOTHER'S MAIDEN NAME Carrie L. Bivins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertensive cardiovascular renal disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 14, 1958 , to December 2, 1958 , and that death occurred at 10:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. M. HARRIS		M.D. V.A. Hospital, Perry Point, Md. 12-2-58	
PHYSICIAN'S NAME (Type) W. M. HARRIS		Acting Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12.5.58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft Myer, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE McGuire Fun. Services, 1820-9th St. N.W. Wash. DC		24a. REC'D BY REGISTRAR DEC 5 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Arlington National

17 Myer, Virginia.

Assistant Director, Professional Services

V.A. Hospital, Perry Point, Md. 12-2-58

XXXXXXXXXXXXXXXXXXXX

November 14 - December 2 - 58 XXXXXXXXXXXXXXXX

VA

Myer

Hypertensive cardiovascular renal disease

Uremia, uremic poisoning

Yes W II unknown Hospital Records, VAH, Perry Point, Md.

Henry G. Davine Garrie L. Davine

Clark

Postal

Georgia

USA

Male Negro

April 10, 1912

46

Lewis M. Davine

Davine

December

58

Veterans Administration Hospital

1427 Irving Street, N.E.

Perry Point 18 days

Washington

Geoff

Hospital of Columbia

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No:

13607

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN ID 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Lawrence Last Blevens Jr				4. DATE OF DEATH Month 12 Day 28 Year 1955			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-58	
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months Days Hours Min.		10. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Lawrence Blevens		14. MOTHER'S MAIDEN NAME Janet Brumit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT James L. Blevens, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				12-29-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-58		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant North East				ADDRESS North East		24a. REC'D BY REGISTRAR DEC 31 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. HARRIS	

9VVVVVVXXVV

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
James Lawrence Alvord		4 months		M.	
Place of Birth		Date of Birth		Date of Death	
North East, Md.		1900-01-01		1900-01-01	
Cause of Death		Disease		Duration	
Pneumonia		Pneumonia		4 months	
Place of Death		Date of Death		Signature of Examiner	
North East, Md.		1900-01-01		J. L. Alvord	
Signature of Physician		Signature of Coroner		Signature of Registrar	
J. L. Alvord		J. L. Alvord		J. L. Alvord	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13608

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Phila.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.O.A. Elkton		c. LENGTH OF STAY IN 1b Enroute		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 75x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS 1752 N. Stillman St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) NATHANIEL L. BROWN			4. DATE OF DEATH Dec. 24, 1958		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/1930		9. AGE (In years last birthday) 28 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucks		11. BIRTHPLACE (State or foreign country) Charleston, S. C.	
12. CITIZEN OF WHAT COUNTRY U.S.A.			13. FATHER'S NAME Sam Brown		
14. MOTHER'S MAIDEN NAME Wilaima No Info.			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Charletta Brown Phila, Penna.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3 in. Laceration of forehead 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed Right Side of Chest DUE TO (c) Crushed Femur					INTERVAL BETWEEN ONSET AND DEATH 5 Min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Over-turn of truck			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 3:45 P.M. 12/24/58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street Rt. 40 North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. C. Dodson			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) R. C. Dodson			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal			22b. DATE THEREOF Dec. 25, 1958		
22c. NAME OF CEMETERY OR CREMATORY Philippine Cemetery			22d. LOCATION (City, town, or county) (State) Phila. Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home			24a. REC'D BY REGISTRAR DEC 29 '58		
ADDRESS Elkton, Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13609

13616 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID First P. Middle DAVIS Sr. Last		4. DATE OF DEATH December 10, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lambert W. Davis		14. MOTHER'S MAIDEN NAME Myra Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-4917	
17. INFORMANT Mrs. Grace Davis,		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1958 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1953 to Dec 10, 1958, that I last saw the deceased alive on Dec 10, 1958, and that death occurred at 8:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/10/58			
ACTUAL SIGNATURE Henry V. Davis M.D.		PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD CHESAPEAKE CITY MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.		22d. LOCATION (City, town, or county) (State) Earleville, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Wellington, Md.		24. REC'D BY REGISTRAR DEC 15 58 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

1901 CERTIFICATE OF DEATH

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Page One, Mr.

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 35 Years		RACE White	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
DATE OF DEATH Jan 12, 1901		TIME OF DEATH 10:30 A.M.	
PLACE OF DEATH Home		CAUSE OF DEATH Typhoid Fever	
DISEASE OR INJURY Typhoid Fever		PERIOD OF ILLNESS 10 Days	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME J. H. Smith & Co.	
NAME OF MINISTER Rev. J. H. Smith		NAME OF BURIAL PLACE Green Mount Cemetery	
NAME OF NEXT OF KIN Mrs. J. H. Harris		NAME OF WITNESS J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film 6237 1-15-59 et
 13630 CERTIFICATE OF DEATH

13610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cleveland Etherington</u>				4. DATE OF DEATH Month Day Year <u>Dec. 28 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1884</u>		9. AGE (In years last birthday) <u>72 74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Etherington</u>				14. MOTHER'S MAIDEN NAME <u>Louise Rossell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Ella Kernan Cecilton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>severe arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Two previous coronary occlusions and very poor myocardium</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28 Dec</u> , 19 <u>58</u> , to <u>28 Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>28 Dec</u> , 19 <u>58</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u>				ADDRESS (Street, city or town, state) <u>M.D. Cecilton, Md.</u>		DATE SIGNED <u>30 Dec 58</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 31, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cecilton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cecilton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows Millington Inf.</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton L. ...</u>	

13617 CERTIFICATE OF DEATH

13611

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>	c. LENGTH OF STAY IN 1b <i>6 hrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Warwick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp.</i>		d. STREET ADDRESS <i>main st.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>David</i> Middle <i>Michael</i> Last <i>Foreaker</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>21</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 4 1958</i>
9. AGE (In years last birthday) <i>6</i> yrs.		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>8</i> Hours <i>12</i> Min.	11. IF UNDER 24 HRS. Hours <i>12</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Elkton, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Franklin D. Foreaker</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Keaton</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Franklin D. Foreaker, Warwick, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Aspiration Pneumonia</i> 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Asphyxia Congenita</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>12</i> Day <i>23</i> Year <i>1958</i> Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 19 <i>58</i> to <i>Dec 21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>21 Dec</i> , 19 <i>58</i> , and that death occurred at <i>2:00</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oshenshain</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecil, Md.</i> DATE SIGNED <i>21 Dec 58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>12/23/58</i>	<i>ELKTON</i>	<i>ELKTON MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Walter</i>		ADDRESS <i>Elkton Md.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 29 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>Charles S. H. H.</i>	

2065232XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

19617 CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. DATE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. PLACE OF BIRTH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. OCCUPATION</p>		<p>10. CAUSE OF DEATH</p>	
<p>11. MANNER OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF CHURCH</p>	
<p>19. SIGNATURE OF MINISTRY</p>		<p>20. SIGNATURE OF FUNERAL HOME</p>	
<p>21. SIGNATURE OF BURIAL</p>		<p>22. SIGNATURE OF CREMATION</p>	
<p>23. SIGNATURE OF INTERMENT</p>		<p>24. SIGNATURE OF REINTERMENT</p>	
<p>25. SIGNATURE OF REINTERMENT</p>		<p>26. SIGNATURE OF REINTERMENT</p>	
<p>27. SIGNATURE OF REINTERMENT</p>		<p>28. SIGNATURE OF REINTERMENT</p>	
<p>29. SIGNATURE OF REINTERMENT</p>		<p>30. SIGNATURE OF REINTERMENT</p>	
<p>31. SIGNATURE OF REINTERMENT</p>		<p>32. SIGNATURE OF REINTERMENT</p>	
<p>33. SIGNATURE OF REINTERMENT</p>		<p>34. SIGNATURE OF REINTERMENT</p>	
<p>35. SIGNATURE OF REINTERMENT</p>		<p>36. SIGNATURE OF REINTERMENT</p>	
<p>37. SIGNATURE OF REINTERMENT</p>		<p>38. SIGNATURE OF REINTERMENT</p>	
<p>39. SIGNATURE OF REINTERMENT</p>		<p>40. SIGNATURE OF REINTERMENT</p>	
<p>41. SIGNATURE OF REINTERMENT</p>		<p>42. SIGNATURE OF REINTERMENT</p>	
<p>43. SIGNATURE OF REINTERMENT</p>		<p>44. SIGNATURE OF REINTERMENT</p>	
<p>45. SIGNATURE OF REINTERMENT</p>		<p>46. SIGNATURE OF REINTERMENT</p>	
<p>47. SIGNATURE OF REINTERMENT</p>		<p>48. SIGNATURE OF REINTERMENT</p>	
<p>49. SIGNATURE OF REINTERMENT</p>		<p>50. SIGNATURE OF REINTERMENT</p>	
<p>51. SIGNATURE OF REINTERMENT</p>		<p>52. SIGNATURE OF REINTERMENT</p>	
<p>53. SIGNATURE OF REINTERMENT</p>		<p>54. SIGNATURE OF REINTERMENT</p>	
<p>55. SIGNATURE OF REINTERMENT</p>		<p>56. SIGNATURE OF REINTERMENT</p>	
<p>57. SIGNATURE OF REINTERMENT</p>		<p>58. SIGNATURE OF REINTERMENT</p>	
<p>59. SIGNATURE OF REINTERMENT</p>		<p>60. SIGNATURE OF REINTERMENT</p>	
<p>61. SIGNATURE OF REINTERMENT</p>		<p>62. SIGNATURE OF REINTERMENT</p>	
<p>63. SIGNATURE OF REINTERMENT</p>		<p>64. SIGNATURE OF REINTERMENT</p>	
<p>65. SIGNATURE OF REINTERMENT</p>		<p>66. SIGNATURE OF REINTERMENT</p>	
<p>67. SIGNATURE OF REINTERMENT</p>		<p>68. SIGNATURE OF REINTERMENT</p>	
<p>69. SIGNATURE OF REINTERMENT</p>		<p>70. SIGNATURE OF REINTERMENT</p>	
<p>71. SIGNATURE OF REINTERMENT</p>		<p>72. SIGNATURE OF REINTERMENT</p>	
<p>73. SIGNATURE OF REINTERMENT</p>		<p>74. SIGNATURE OF REINTERMENT</p>	
<p>75. SIGNATURE OF REINTERMENT</p>		<p>76. SIGNATURE OF REINTERMENT</p>	
<p>77. SIGNATURE OF REINTERMENT</p>		<p>78. SIGNATURE OF REINTERMENT</p>	
<p>79. SIGNATURE OF REINTERMENT</p>		<p>80. SIGNATURE OF REINTERMENT</p>	
<p>81. SIGNATURE OF REINTERMENT</p>		<p>82. SIGNATURE OF REINTERMENT</p>	
<p>83. SIGNATURE OF REINTERMENT</p>		<p>84. SIGNATURE OF REINTERMENT</p>	
<p>85. SIGNATURE OF REINTERMENT</p>		<p>86. SIGNATURE OF REINTERMENT</p>	
<p>87. SIGNATURE OF REINTERMENT</p>		<p>88. SIGNATURE OF REINTERMENT</p>	
<p>89. SIGNATURE OF REINTERMENT</p>		<p>90. SIGNATURE OF REINTERMENT</p>	
<p>91. SIGNATURE OF REINTERMENT</p>		<p>92. SIGNATURE OF REINTERMENT</p>	
<p>93. SIGNATURE OF REINTERMENT</p>		<p>94. SIGNATURE OF REINTERMENT</p>	
<p>95. SIGNATURE OF REINTERMENT</p>		<p>96. SIGNATURE OF REINTERMENT</p>	
<p>97. SIGNATURE OF REINTERMENT</p>		<p>98. SIGNATURE OF REINTERMENT</p>	
<p>99. SIGNATURE OF REINTERMENT</p>		<p>100. SIGNATURE OF REINTERMENT</p>	

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13631
CERTIFICATE OF DEATH

13612

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 27yrs. 7mo. 12days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3004 Harlem Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last HAYDEN		4. DATE OF DEATH Month December Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-94
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64	
11. IF UNDER 24 HRS. Days 64		12. Hours 64	
13. Min. 64		14. IF UNDER 24 HRS. Min. 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Riveter		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Hayden		14. MOTHER'S MAIDEN NAME Mary Loretta Tansey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21 , 19 51 , to December 3 , 19 58 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 12-4-58			
ACTUAL SIGNATURE W. M. HARRIS		M.D. V.A. Hospital, Perry Point, Md. 12-4-58	
PHYSICIAN'S NAME (Type) W. M. HARRIS		Acting Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/58	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HARRY H. WITZKE		ADDRESS 4101 Edmondson Ave. Balto. Md.	
24a. REC'D BY REGISTRAR DEC 5 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

Reg. Dist. No. 96

MEDICAL CERTIFICATION

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13615

13634

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		STATE Maryland		COUNTY Cecil			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural		LENGTH OF STAY (in this place) 40 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Frances E. Jackson				4. DATE OF DEATH (Month) (Day) (Year) 12 31 19 58			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12-17- 1890	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U S A
13. FATHER'S NAME Patrick Murphy				14. MOTHER'S MAIDEN NAME Hannah Hickey Md			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Chester S. Jackson. Port Deposit,			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Stenosis						3 1/2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocarditis						6 yrs -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not white at work <input type="checkbox"/> White at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec-14-58, to Dec-27-58, that I last saw the deceased alive on Dec-30, 1958, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
SIGNATURE Clarence H. Johnson		M.D.		ADDRESS (Street, city, town, state) Port Deposit, Md		DATE SIGNED 1/1/59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-3-1959		NAME OF CEMETERY OR CREMATORY Brookview Cem.		LOCATION (City, town, or county) (State) Rising Sun, Md.	
24. REC'D BY REGISTRAR JAN 5 '59		REGISTRAR'S SIGNATURE Carlton S. House		25. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson			
				ADDRESS Perryville, Md			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13635 CERTIFICATE OF DEATH

13616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Arlington STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2719 S. Wayne Street	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last JAMES		4. DATE OF DEATH Month December Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-01
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 26 Hours 1958 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Wachapreague, Virginia.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alford G. James		14. MOTHER'S MAIDEN NAME Georgie Nock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 040-14-2834	
17. INFORMANT Hospital Records, VAH, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, severe 420.0 DUE TO Arteriosclerosis, generalized, severe Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Unknown (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 10, 1958 , to Dec. 26, 1958 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph C. Grasberger		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 12-27-58	
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D. Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/30/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Funerary Services, Inc., Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JAN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director, or the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13636 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 1 mo. 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V/A. Hospital, Perry Point, Md.		e. IS RESIDENCE ON A FARM? unknown	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last JOHNSON		4. DATE OF DEATH Month December Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-01
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Johnson		14. MOTHER'S MAIDEN NAME Dora Mae Anthony	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 222-03-8773	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X Bronchopneumonia left lower lobes unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema bullous bilateral upper lobes and DUE TO bronchiectasis bilateral severe, lower lobes (c) unknown INTERVAL BETWEEN ONSET AND DEATH 3-4 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Arteriosclerosis, generalized, moderately severe	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 19 58 to December 17, 19 58 and that death occurred at 11:40 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>S. P. Lacerva</i>		M.D. V.A. Hospital, Perry Point, Md. 12-17-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-1958	
22c. NAME OF CEMETERY OR CREMATORY Bayview Methodist		22d. LOCATION (City, town, or county) (State) Bayview, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS Joseph R. Grant, Northeast, Maryland	
24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krowa</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Joseph A. Grant, Northeast, Maryland

Revised by: [illegible]

Director, Physiological Services

V.A. Hospital, Terry Point, Md. 11-17-55

December 31 58 December 17 58

arteriosclerosis, generalized, moderately severe

bronchiectasis bilateral severe, lower lobes
emphysema bilateral upper lobes and

chronopneumonia left lower lobes unresolved 5-4 days

Yes VV II

228-07-8775 Hospital Records, V.A. Terry Point, Md.

John F. Johnson

Porter Lee Anthony

Electrician

Self-employed

Married

USA

Male

White

7-21-31

57

WILLIAM

JOHNSON

December 17

UNKNOWN

V.A. Hospital, Terry Point, Md.

E.D. 17

Terry Point, Md.

1 mo. 25 days

Next date

Cecil

1 mo. 1 day

Cecil

CERTIFICATE OF DEATH

18888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

13637

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mt. Goral Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Vernon</i> Middle <i>S.</i> Last <i>Jones</i>				4. DATE OF DEATH Month <i>12</i> Day <i>7</i> Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 25, 1892</i>	9. AGE (In years last birthday) <i>66 yrs.</i>	IF UNDER 1 YEAR Months <i>X</i> Days <i>12</i>	IF UNDER 24 HRS. Hours <i>12</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>		11. BIRTHPLACE (State or foreign country) <i>Conowingo, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William James Jones</i>				14. MOTHER'S MAIDEN NAME <i>Jessie Bradford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-20-7940</i>		17. INFORMANT Address <i>Mrs. Virian Henry - Haver de Grace, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>5 years</i>						INTERVAL BETWEEN ONSET AND DEATH <i>one wk.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>6/1</i> , 19 <i>54</i> to <i>12/7</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>12/6</i> , 19 <i>58</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Neil Taylor</i> M.D.				ADDRESS (Street, city or town, state) <i>Rising Sun, Md.</i> DATE SIGNED <i>12/9/58</i>			
PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr</i>				<i>Rising Sun, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>12-10-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Goral Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Conowingo Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clara G. Bullock - Haver de Grace, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John S. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, RFD</u>		c. LENGTH OF STAY IN lb <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>O.</u> Last <u>Keith</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
13. FATHER'S NAME <u>William Keith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>156-05-2310</u>	
17. INFORMANT <u>Geneva H. Keith, Port Deposit, RFD, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/17/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit RFD, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson + Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

13618 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>34 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Childs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>				d. STREET ADDRESS <u>Childs</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>A</u> Last <u>Kirkpatrick</u>				4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 10 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Deirling</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gatten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs Margaret Hasson</u>	
				Address <u>Childs, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
				20f. (City or town) <u>Childs</u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>March 21 1956</u> to <u>Dec. 5 1958</u> , that I last saw the deceased alive on <u>Dec 5 1958</u> , and that death occurred at <u>2:50p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				M.D. <u> </u>		ADDRESS (Street, city or town, state) <u>233 E. Main Street</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr. M.D.</u>						DATE SIGNED <u>12/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

13639

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			c. LENGTH OF STAY IN 1b 40 years X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter P. Lewis				4. DATE OF DEATH Month 12 Day 9 Year 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman Retired 10 yrs			10b. KIND OF BUSINESS OR INDUSTRY Penna R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David Lewis				14. MOTHER'S MAIDEN NAME Sabina Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 717-07-5362		17. INFORMANT Address Mrs Georgiana Lewis North East, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) GENERALIZED ARTERIO SCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 10 min. YEARS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 20, 1958, to Dec 9, 1958, that I last saw the deceased alive on Dec 1, 1958, and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED NORTH EAST, Md. 12-9-58							
ACTUAL SIGNATURE Luis M. Cuza				M.D. NORTH EAST, Md. 12-9-58			
PHYSICIAN'S NAME (Type) Luis M. Cuza							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-1958		22c. NAME OF CEMETERY OR CREMATORY Principio Methodist		22d. LOCATION (City, town, or county) (State) Principio, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Brand North East, Maryland				24a. REC'D BY REGISTRAR DATE DEC 12 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Truitt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

13619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 80 d.ays	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olive Middle Shallcross Last Lowe		4. DATE OF DEATH Month 12 Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hiram W. Shallcross	
14. MOTHER'S MAIDEN NAME Anna Abbott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, no, or unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Bessie M Bailiff Address North East (Rural)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Coma DUE TO 3 04 4 days (c) Diabetes. 10 years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Gangrene Diabetic Gangrene of foot			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A mputation of left foreleg Nov 18/58	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 13 , 1958, to Dec 2 , 1958, that I last saw the deceased alive on Dec 2 , 1958, and that death occurred at 2:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Maryland DATE SIGNED Wells East, Maryland ACTUAL SIGNATURE H. Arthur Cantwell M.D. Wells East, Maryland PHYSICIAN'S NAME (Type) H. Arthur Cantwell M.D. North East, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 6, 1958	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East (Cecil Co) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Md		24a. REC'D BY REGISTRAR DATE DEC 4 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13620 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton, R.D.#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry Armstrong Lungren		4. DATE OF DEATH Dec 10 1958 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Lungren		14. MOTHER'S MAIDEN NAME Martha Ferguson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Minnie Kerr Lungren, R. D. 3, Elkton		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1958, to Dec 10, 1958, that I last saw the deceased alive and Dec 10, 1958, and that death occurred at 12 noon from the causes and on the date stated above.			
ACTUAL SIGNATURE F. B. Robinson		ADDRESS (Street, city or town, state) Oxford, Penna.	
DATE SIGNED Dec 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1922 CERTIFICATE OF DEATH

Page No. 10

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45 years"]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1877"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Clerk"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		DATE OF DEATH [Faint text, possibly "Dec 10, 1922"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE OF DEATH [Faint text, possibly "This is to certify that the above named person died on the 10th day of December, 1922, at the age of 45 years, of Heart Disease, at his home, Baltimore, Md."]		[Faint text, possibly "Witnessed by"]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b All life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William J. McCall		4. DATE OF DEATH Month Day Year 12-17-1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis G. McCall		14. MOTHER'S MAIDEN NAME Carrie Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-07-8964	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-19-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-58	
22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Hunt		ADDRESS North East, Md.	
24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Carlton L. Hunt	

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INTRODUCTION

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Abstracts of the Proceedings of the 1994 Annual Meeting of the American Psychological Association, Washington, DC, August 12-16, 1994.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13625

13641 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 3Yrs, 4Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3v01-4			
d. STREET ADDRESS 2823 Overland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM First P. Middle MCGUIRE Last				4. DATE OF DEATH Month 12 Day 21 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-91	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY Industry		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME J. MATTHEW MCGUIRE (D)				14. MOTHER'S MAIDEN NAME MARY A. MANGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW1				16. SOCIAL SECURITY NO. 216 22 4717		17. INFORMANT Address HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c) Arteriosclerosis, general							INTERVAL BETWEEN ONSET AND DEATH 5 days 9 months 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) VA			20g. (County) VA		20h. (State) VA		
21. I certify that I attended the deceased from 8-29- 19 55 , to 12-21- 19 58 , and that death occurred at 3:40A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Burke Suitt M.D. VA Hospital, Perry Point, Md. DATE SIGNED 12-21-58							
PHYSICIAN'S NAME (Type) R. Burke Suitt, M.D. Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/58		22c. NAME OF CEMETERY OR CREMATORY Catharine		22d. LOCATION (City, town, or county) (State) 4300000 Frederick Rd	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Foley 1318 Sigel St				24a. REC'D BY REGISTRAR DATE DEC 24 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Place of Death		Occupation		Signature of Physician	
Signature of Registrar		Date of Registration		Place of Registration	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13621 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13621

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 306 Penna. Ave.		d. STREET ADDRESS 306 Penna. Ave.	
3. NAME OF DECEASED (Type or print) Herbert Gray Mc Neal		4. DATE OF DEATH December 10, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Worker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Mc Neal		14. MOTHER'S MAIDEN NAME India T. Logan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-8131	
17. INFORMANT Vernon Mc Neal		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 Min. 10 Years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		24a. REC'D BY REGISTRAR DEC 15 '58	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Anthony S. Kraus	

13627

13622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp</u>				d. STREET ADDRESS <u>Union Hosp.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Evan</u> Last <u>Milburn</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20 1956</u>		9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>3 22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Trimble Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hallen Mackie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>JOHN T. MILBURN ELKTON, MD, RD #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature rupture of membrane</u> DUE TO (c) <u>2 weeks</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intrauterine infection &/or Hgeline membrane D.D.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 20 1958</u> to <u>Dec 20 1958</u> that I last saw the deceased alive on <u>Dec 20 1958</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecil, Md</u> DATE SIGNED <u>20 Dec 58</u>			
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HEAD OF CHRISTIANA</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.T. Jones</u> ADDRESS <u>Newark, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

2065192XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. SMITH		2. SEX MALE	
3. DATE OF BIRTH 10-15-1915		4. PLACE OF BIRTH NEW YORK, N.Y.	
5. OCCUPATION LABORER		6. CAUSE OF DEATH HEART DISEASE	
7. DATE OF DEATH 10-25-1965		8. PLACE OF DEATH HOME	
9. TIME OF DEATH 10:30 P.M.		10. SIGNATURE OF DECEASED JOHN J. SMITH	
11. SIGNATURE OF WITNESSES JOHN J. SMITH		12. SIGNATURE OF DECEASED JOHN J. SMITH	
13. SIGNATURE OF DECEASED JOHN J. SMITH		14. SIGNATURE OF DECEASED JOHN J. SMITH	
15. SIGNATURE OF DECEASED JOHN J. SMITH		16. SIGNATURE OF DECEASED JOHN J. SMITH	
17. SIGNATURE OF DECEASED JOHN J. SMITH		18. SIGNATURE OF DECEASED JOHN J. SMITH	
19. SIGNATURE OF DECEASED JOHN J. SMITH		20. SIGNATURE OF DECEASED JOHN J. SMITH	
21. SIGNATURE OF DECEASED JOHN J. SMITH		22. SIGNATURE OF DECEASED JOHN J. SMITH	
23. SIGNATURE OF DECEASED JOHN J. SMITH		24. SIGNATURE OF DECEASED JOHN J. SMITH	
25. SIGNATURE OF DECEASED JOHN J. SMITH		26. SIGNATURE OF DECEASED JOHN J. SMITH	
27. SIGNATURE OF DECEASED JOHN J. SMITH		28. SIGNATURE OF DECEASED JOHN J. SMITH	
29. SIGNATURE OF DECEASED JOHN J. SMITH		30. SIGNATURE OF DECEASED JOHN J. SMITH	
31. SIGNATURE OF DECEASED JOHN J. SMITH		32. SIGNATURE OF DECEASED JOHN J. SMITH	
33. SIGNATURE OF DECEASED JOHN J. SMITH		34. SIGNATURE OF DECEASED JOHN J. SMITH	
35. SIGNATURE OF DECEASED JOHN J. SMITH		36. SIGNATURE OF DECEASED JOHN J. SMITH	
37. SIGNATURE OF DECEASED JOHN J. SMITH		38. SIGNATURE OF DECEASED JOHN J. SMITH	
39. SIGNATURE OF DECEASED JOHN J. SMITH		40. SIGNATURE OF DECEASED JOHN J. SMITH	
41. SIGNATURE OF DECEASED JOHN J. SMITH		42. SIGNATURE OF DECEASED JOHN J. SMITH	
43. SIGNATURE OF DECEASED JOHN J. SMITH		44. SIGNATURE OF DECEASED JOHN J. SMITH	
45. SIGNATURE OF DECEASED JOHN J. SMITH		46. SIGNATURE OF DECEASED JOHN J. SMITH	
47. SIGNATURE OF DECEASED JOHN J. SMITH		48. SIGNATURE OF DECEASED JOHN J. SMITH	
49. SIGNATURE OF DECEASED JOHN J. SMITH		50. SIGNATURE OF DECEASED JOHN J. SMITH	
51. SIGNATURE OF DECEASED JOHN J. SMITH		52. SIGNATURE OF DECEASED JOHN J. SMITH	
53. SIGNATURE OF DECEASED JOHN J. SMITH		54. SIGNATURE OF DECEASED JOHN J. SMITH	
55. SIGNATURE OF DECEASED JOHN J. SMITH		56. SIGNATURE OF DECEASED JOHN J. SMITH	
57. SIGNATURE OF DECEASED JOHN J. SMITH		58. SIGNATURE OF DECEASED JOHN J. SMITH	
59. SIGNATURE OF DECEASED JOHN J. SMITH		60. SIGNATURE OF DECEASED JOHN J. SMITH	
61. SIGNATURE OF DECEASED JOHN J. SMITH		62. SIGNATURE OF DECEASED JOHN J. SMITH	
63. SIGNATURE OF DECEASED JOHN J. SMITH		64. SIGNATURE OF DECEASED JOHN J. SMITH	
65. SIGNATURE OF DECEASED JOHN J. SMITH		66. SIGNATURE OF DECEASED JOHN J. SMITH	
67. SIGNATURE OF DECEASED JOHN J. SMITH		68. SIGNATURE OF DECEASED JOHN J. SMITH	
69. SIGNATURE OF DECEASED JOHN J. SMITH		70. SIGNATURE OF DECEASED JOHN J. SMITH	
71. SIGNATURE OF DECEASED JOHN J. SMITH		72. SIGNATURE OF DECEASED JOHN J. SMITH	
73. SIGNATURE OF DECEASED JOHN J. SMITH		74. SIGNATURE OF DECEASED JOHN J. SMITH	
75. SIGNATURE OF DECEASED JOHN J. SMITH		76. SIGNATURE OF DECEASED JOHN J. SMITH	
77. SIGNATURE OF DECEASED JOHN J. SMITH		78. SIGNATURE OF DECEASED JOHN J. SMITH	
79. SIGNATURE OF DECEASED JOHN J. SMITH		80. SIGNATURE OF DECEASED JOHN J. SMITH	
81. SIGNATURE OF DECEASED JOHN J. SMITH		82. SIGNATURE OF DECEASED JOHN J. SMITH	
83. SIGNATURE OF DECEASED JOHN J. SMITH		84. SIGNATURE OF DECEASED JOHN J. SMITH	
85. SIGNATURE OF DECEASED JOHN J. SMITH		86. SIGNATURE OF DECEASED JOHN J. SMITH	
87. SIGNATURE OF DECEASED JOHN J. SMITH		88. SIGNATURE OF DECEASED JOHN J. SMITH	
89. SIGNATURE OF DECEASED JOHN J. SMITH		90. SIGNATURE OF DECEASED JOHN J. SMITH	
91. SIGNATURE OF DECEASED JOHN J. SMITH		92. SIGNATURE OF DECEASED JOHN J. SMITH	
93. SIGNATURE OF DECEASED JOHN J. SMITH		94. SIGNATURE OF DECEASED JOHN J. SMITH	
95. SIGNATURE OF DECEASED JOHN J. SMITH		96. SIGNATURE OF DECEASED JOHN J. SMITH	
97. SIGNATURE OF DECEASED JOHN J. SMITH		98. SIGNATURE OF DECEASED JOHN J. SMITH	
99. SIGNATURE OF DECEASED JOHN J. SMITH		100. SIGNATURE OF DECEASED JOHN J. SMITH	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13623

Item 2 Film 6237 1-7-59 et

CERTIFICATE OF DEATH

13628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 3 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charlatte J. Plummer				4. DATE OF DEATH Month Day Year Dec. 13th 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13th 1870	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeping		10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Mark Manlove			
14. MOTHER'S MAIDEN NAME Ella Conlin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Lulu P. Brustle 6445 Market St. Upper			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe generalized arthritis				INTERVAL BETWEEN ONSET AND DEATH unknown Pa.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 7/18/53 , 19____, to 12/13/ 1958 , that I last saw the deceased alive on 12/13/ 1958 , and that death occurred at 813 p.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.				ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland			
DATE SIGNED 12/14/58				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 12/16/58				22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery			
22d. LOCATION (City, town, or county) (State) Chesapeake City Md.				23. FUNERAL DIRECTOR'S SIGNATURE A. L. Daniels Middletown Del.			
24a. REC'D BY REGISTRAR DEC 17 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G237 1-9-59 et

13624

CERTIFICATE OF DEATH

13629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Private home"				d. STREET ADDRESS Earleville			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SUSIE Middle ELLA Last PRICE				4. DATE OF DEATH Month December Day 26 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1899	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles H. Bailey				14. MOTHER'S MAIDEN NAME Duna See			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT James H. Price,				Address Earleville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of Sigmoid DUE TO (c) 2 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept , 19 58 , to 26 Dec , 19 58 , that I last saw the deceased alive on 26 Dec , 19 58 , and that death occurred at 7:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md DATE SIGNED 27 Dec 58							
ACTUAL SIGNATURE Wallace Obenshain M.D.							
PHYSICIAN'S NAME (Type) WALLACE OBENSHAIN CECILTON, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1958		22c. NAME OF CEMETERY OR CREMATORY Galena Cem.		22d. LOCATION (City, town, or county) (State) Galena, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows,				ADDRESS Belleville, Md.		24a. REC'D BY REGISTRAR DATE DEC 30 '58	
24b. REGISTRAR'S SIGNATURE Charles S. Kline							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13642 CERTIFICATE OF DEATH

13630
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 8yrs8mos3days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk		83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5839 - 6th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OTIS Middle ODELL Last SAUNDERS		4. DATE OF DEATH Month December Day 31 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 9, 1923
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min.	IF UNDER 24 HRS. Months 35 Days 35 Hours 35 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME B. E. SAUNDERS		14. MOTHER'S MAIDEN NAME Mimmie Irene Twine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If given, give number or dates of service) 245-16-3493	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last, (b) Tuberculosis, active DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH Over 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. WA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28 , 19 50 , to December 31 , 19 58 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 1-2-59			
ACTUAL SIGNATURE W. M. HARRIS		PHYSICIAN'S NAME (Type) W. M. HARRIS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/5/1959	
22c. NAME OF CEMETERY OR CREMATORY Hampton National		22d. LOCATION (City, town, or county) (State) Hampton, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington		ADDRESS Havre DeGrace, Md.	
24a. REC'D BY REGISTRAR JAN 7 '59		24b. REGISTRAR'S SIGNATURE William S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01500

Abstract: The purpose of this study was to determine the effect of a 12-week training program on the physical fitness and health of middle-aged women. The study was conducted in a community-based setting. The participants were 30 middle-aged women who were randomly selected from a local health center. The training program consisted of three sessions per week, each lasting 45 minutes. The sessions included aerobic exercise, strength training, and flexibility exercises. The physical fitness and health of the participants were measured at the beginning and end of the training program. The results of the study showed that the training program had a significant positive effect on the physical fitness and health of the participants. The participants showed significant improvements in their aerobic fitness, strength, and flexibility. Additionally, the participants reported a decrease in their body mass index (BMI) and an increase in their overall health. The study suggests that a 12-week training program can be an effective way to improve the physical fitness and health of middle-aged women.

Interpolari, 1993

Q. 5-1. 2010-11-11 10:10:11

Acting Director, Professional Services

CIVIL ENGINEERING • H • 9

13643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Newark R.D. 2 Del.</u>		c. LENGTH OF STAY IN 1b <u>69 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>J.</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 23, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wesley Price</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mrs. Lillie Peterson, R. D. 2, Newark, Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 10</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 9</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Hughes Nutter</u>		ADDRESS (Street, city or town, state) <u>106 Haines St Newark, DEL.</u>	
PHYSICIAN'S NAME (Type) <u>E. HUGHES NUTTER</u>		DATE SIGNED <u>12-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cecil County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '58</u>	
ADDRESS <u>Elkton, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See this side

<p>1. Name of deceased: <u>John William Jones</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1880</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>Jan 25, 1940</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Usual place of abode: <u>St. Louis, Mo.</u></p>	
<p>11. Name of attending physician: <u>Dr. J. B. Smith</u></p>		<p>12. Name of informant: <u>John Jones</u></p>	
<p>13. Signature of physician: <u>[Signature]</u></p>		<p>14. Signature of informant: <u>[Signature]</u></p>	
<p>15. Date of completion: <u>Jan 26, 1940</u></p>		<p>16. Name of registrar: <u>John Jones</u></p>	
<p>17. Name of registrar: <u>John Jones</u></p>		<p>18. Name of registrar: <u>John Jones</u></p>	
<p>19. Name of registrar: <u>John Jones</u></p>		<p>20. Name of registrar: <u>John Jones</u></p>	
<p>21. Name of registrar: <u>John Jones</u></p>		<p>22. Name of registrar: <u>John Jones</u></p>	
<p>23. Name of registrar: <u>John Jones</u></p>		<p>24. Name of registrar: <u>John Jones</u></p>	
<p>25. Name of registrar: <u>John Jones</u></p>		<p>26. Name of registrar: <u>John Jones</u></p>	
<p>27. Name of registrar: <u>John Jones</u></p>		<p>28. Name of registrar: <u>John Jones</u></p>	
<p>29. Name of registrar: <u>John Jones</u></p>		<p>30. Name of registrar: <u>John Jones</u></p>	
<p>31. Name of registrar: <u>John Jones</u></p>		<p>32. Name of registrar: <u>John Jones</u></p>	
<p>33. Name of registrar: <u>John Jones</u></p>		<p>34. Name of registrar: <u>John Jones</u></p>	
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<p>37. Name of registrar: <u>John Jones</u></p>		<p>38. Name of registrar: <u>John Jones</u></p>	
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<p>41. Name of registrar: <u>John Jones</u></p>		<p>42. Name of registrar: <u>John Jones</u></p>	
<p>43. Name of registrar: <u>John Jones</u></p>		<p>44. Name of registrar: <u>John Jones</u></p>	
<p>45. Name of registrar: <u>John Jones</u></p>		<p>46. Name of registrar: <u>John Jones</u></p>	
<p>47. Name of registrar: <u>John Jones</u></p>		<p>48. Name of registrar: <u>John Jones</u></p>	
<p>49. Name of registrar: <u>John Jones</u></p>		<p>50. Name of registrar: <u>John Jones</u></p>	
<p>51. Name of registrar: <u>John Jones</u></p>		<p>52. Name of registrar: <u>John Jones</u></p>	
<p>53. Name of registrar: <u>John Jones</u></p>		<p>54. Name of registrar: <u>John Jones</u></p>	
<p>55. Name of registrar: <u>John Jones</u></p>		<p>56. Name of registrar: <u>John Jones</u></p>	
<p>57. Name of registrar: <u>John Jones</u></p>		<p>58. Name of registrar: <u>John Jones</u></p>	
<p>59. Name of registrar: <u>John Jones</u></p>		<p>60. Name of registrar: <u>John Jones</u></p>	
<p>61. Name of registrar: <u>John Jones</u></p>		<p>62. Name of registrar: <u>John Jones</u></p>	
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<p>77. Name of registrar: <u>John Jones</u></p>		<p>78. Name of registrar: <u>John Jones</u></p>	
<p>79. Name of registrar: <u>John Jones</u></p>		<p>80. Name of registrar: <u>John Jones</u></p>	
<p>81. Name of registrar: <u>John Jones</u></p>		<p>82. Name of registrar: <u>John Jones</u></p>	
<p>83. Name of registrar: <u>John Jones</u></p>		<p>84. Name of registrar: <u>John Jones</u></p>	
<p>85. Name of registrar: <u>John Jones</u></p>		<p>86. Name of registrar: <u>John Jones</u></p>	
<p>87. Name of registrar: <u>John Jones</u></p>		<p>88. Name of registrar: <u>John Jones</u></p>	
<p>89. Name of registrar: <u>John Jones</u></p>		<p>90. Name of registrar: <u>John Jones</u></p>	
<p>91. Name of registrar: <u>John Jones</u></p>		<p>92. Name of registrar: <u>John Jones</u></p>	
<p>93. Name of registrar: <u>John Jones</u></p>		<p>94. Name of registrar: <u>John Jones</u></p>	
<p>95. Name of registrar: <u>John Jones</u></p>		<p>96. Name of registrar: <u>John Jones</u></p>	
<p>97. Name of registrar: <u>John Jones</u></p>		<p>98. Name of registrar: <u>John Jones</u></p>	
<p>99. Name of registrar: <u>John Jones</u></p>		<p>100. Name of registrar: <u>John Jones</u></p>	

13625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 MANOR RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robena</u> Middle <u>Clara</u> Last <u>SPENCER</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1872</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Clara Emline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Denton Williams, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443x</u> IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 5, 1956</u> to <u>December 8, 1958</u> , that I last saw the deceased alive on <u>December 6, 1958</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) <u>233 E. Main Street</u>		DATE SIGNED <u>12/8/58</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Mercer County WVA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter de Boer, Jr.</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13644

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON Rural</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ELKTON Rural</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural ELKTON</u>			
				d. STREET ADDRESS <u>1 Rd # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Starth</u> Last <u>Starth</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4 1882</u>	
				9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Starth</u>				14. MOTHER'S MAIDEN NAME <u>Verma Lane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-10-3295</u>			
				17. INFORMANT <u>Mary Starth, ELKTON</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> to <u>Dec. 6</u> , 1958, that I last saw the deceased alive on <u>Dec. 6</u> , 1958, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>ELKTON, MD</u> DATE SIGNED <u>Dec. 6, 1958</u>							
ACTUAL SIGNATURE <u>Dr. Paul H. Sprecher</u> M.D.				PHYSICIAN'S NAME (Type) <u>ELKTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON Cem.</u>	
				22d. LOCATION (City, town, or county) <u>ELKTON</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter du Bose, Jr.</u> ADDRESS <u>ELKTON, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13645 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg	
c. LENGTH OF STAY IN 1b 30yrs.5mo.19days		85 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 504 Monticello Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		unknown	
3. NAME OF DECEASED (Type or print) First HARRY Middle (NMI) Last STROTHER		4. DATE OF DEATH Month December Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-11-88
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Consolidated Coal	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles J. Strother		14. MOTHER'S MAIDEN NAME Nancy Ann Swager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 7-10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized - unknown 491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 1928 , to December 12, 1958 , and that death occurred at 9:40 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 12-12-58			
ACTUAL SIGNATURE S. P. LACERVA		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/13/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn		22d. LOCATION (City, town, or county) (State) Clarksburg, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DEC 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Receives and Swaps

Charles J. Stroh

Geological Records, VAN, Ferry Point, ME.

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Arteriosclerosis of the heart disease, severe

unknown - Description: none

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U.S. Hospital, Perry Point, Md. 12-12-35

Director, Professional Services

2 • 9 • 4

1944-1945, 1946-1947, 1948-1949, 1950-1951, 1952-1953, 1954-1955, 1956-1957, 1958-1959, 1960-1961, 1962-1963, 1964-1965, 1966-1967, 1968-1969, 1970-1971, 1972-1973, 1974-1975, 1976-1977, 1978-1979, 1980-1981, 1982-1983, 1984-1985, 1986-1987, 1988-1989, 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 2684-2685, 2686-2687, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13635

13646

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street	
c. LENGTH OF STAY IN 1b 20 days		d. STREET ADDRESS 12 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? unknown	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES S. WALTER JR		4. DATE OF DEATH Month Day Year December 14 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-26-21
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles S. Walter, Sr.		14. MOTHER'S MAIDEN NAME Ethel Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218 18 1063	
17. INFORMANT V.A. Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis localized and diffuse 5870 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extravasated contents of viscera DUE TO Abscess of the pancreas (c) Chronic pancreatitis due to infection Non-specific PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3-4 days unknown unknown unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24 19 58 , to December 14 19 58 , and that death occurred at 8:20 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE S. P. LACERVA		M.D. V.A. Hospital, Perry Point, Md. 12-15-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/17/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor		22d. LOCATION (City, town, or county) (State) Belair, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DEC 18 58		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

13647

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CDC II MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. LENGTH OF STAY IN 1b 3mths. 12days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS JOPPA 12X-2	
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT A. WILLIAMS		4. DATE OF DEATH Month Day Year December 7, 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE WILLIAMS		14. MOTHER'S MAIDEN NAME ELLEN GIBSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-20-7765	
17. INFORMANT Hosp. Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic heart disease DUE TO unknown (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X INTERVAL BETWEEN ONSET AND DEATH 6-7 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 26, 1958 , to Dec. 7, 1958 , and that death occurred at 5:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 12-8-58			
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-58	22c. NAME OF CEMETERY OR CREMATORY Mountain Cemetery	22d. LOCATION (City, town, or county) (State) Joppa, Md.
23. FUNERAL DIRECTOR'S SIGNATURE BULLOCK'S MORTUARY,		24a. REC'D BY REGISTRAR Havre DeGrace, Md. DATE DEC 15 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-6-58

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13637

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Lewis O Williams				4. DATE OF DEATH Month 12 Day 22 Year 19 58			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1904		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Owner		10b. KIND OF BUSINESS OR INDUSTRY Garage Repair		11. BIRTHPLACE (State or foreign country) Culpepper, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Collins S Williams				14. MOTHER'S MAIDEN NAME Margarette Sheppard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-24-0138		17. INFORMANT Address Margarette Williams North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis with myocarditis Cardiac Failure 592x DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-23-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-26-58		22c. NAME OF CEMETERY OR CREMATORY Signum Cem		22d. LOCATION (City, town, or county) (State) Culpepper, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson				24a. REC'D BY REGISTRAR Arthur S. Thomas		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
				DATE DEC 29 '58			

1931

1931

1931

North East

20 yrs

North East

Williams

0

1931

1931-1931

X

0

1

U.S.A.

Guantanamo, Va.

Guantanamo, Va.

Guantanamo, Va.

Lawrence G. Shapard

Colin S. Williams

Lawrence G. Shapard

no

Chronic hepatitis with necrotic changes

hypertension

X

X

X

1931-1931

X

1931-1931

1931

13649 CERTIFICATE OF DEATH

14426

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 28yrs.6mo.17days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1716 Byrd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last WILLIAMS		4. DATE OF DEATH Month December Day 31 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-21-96
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Williams	
14. MOTHER'S MAIDEN NAME Agnes McGee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of myocardium secondary to infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Approx. 10 minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 14 19 30 , to December 31 19 58 , and that death occurred at 8:20a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. HARRIS		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. 1-2-59	
PHYSICIAN'S NAME (Type) W. M. HARRIS		DATE SIGNED Acting Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/6/59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JAN 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

14488

98

Name of Deceased		George Williams	
Sex		Male	
Date of Birth		11-21-96	
Place of Birth		Maryland	
Usual Residence		Baltimore	
Cause of Death		Myocardium secundum	
Manner of Death		Intoxication	
Hospital Record, Y/N		Yes	
Hospital Name		Ferry Point, Md.	
Date of Death		June 14, 1950	
Time of Death		8:30 A.M.	
Physician		W. H. Morris	
Address		Baltimore, Md.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13650

CERTIFICATE OF DEATH

13638

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Howard		(Middle) Marshall		(Last) Wilson		(Month) (Day) (Year) Dec. 4 1958	
5. SEX male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 20, 1879	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Cecil County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Wilson				14. MOTHER'S MAIDEN NAME Elizabeth Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 219-01-0395		17. INFORMANT & ADDRESS William McNamee, Rising Sun, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Chronic Myocarditis 2 yrs.							
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1 , 19 56 , to Dec. 4 , 19 58 , that I last saw the deceased alive on Dec. 2 , 19 58 , and that death occurred at 5 A. M., from the causes and on the date stated above.							
SIGNATURE W. L. Dodson				ADDRESS (Street, city, town, state) Rising Sun Md.		DATE SIGNED 12-5-58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 6, '58		NAME OF CEMETERY OR CREMATORY Brookview		LOCATION (City, town, or county) (State) Rising Sun Md.	
24. REC'D BY REGISTRAR DATE DEC 8 '58		REGISTRAR'S SIGNATURE Chas. E. Turner		25. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun Md.	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle S Last Wood Sr.				4. DATE OF DEATH December 16 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1900	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William S. Wood				14. MOTHER'S MAIDEN NAME Mollie Crouch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-16-5632		17. INFORMANT Mrs. Jane Fuddy Wood Address North East R.D. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.1 Nephrosis, lower nephron DUE TO Polycystic Kidneys. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Splenomegaly, Cause undetermined							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/8 1958, to 12/16 1958, that I last saw the deceased alive on 12/16/58, 1958, and that death occurred at 12:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer				ADDRESS (Street, city or town, state) 162 W. MAIN ST. Md.		DATE SIGNED 12/16/58	
PHYSICIAN'S NAME (Type) John A. Fischer				EIKTON, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/58		22c. NAME OF CEMETERY OR CREMATORY Harts Methodist Cemetery		22d. LOCATION (City, town, or county) (State) North East (Rural) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Thurst				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE DEC 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13640

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.	
c. LENGTH OF STAY IN 1b 16yrs		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital, D.O.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel York		4. DATE OF DEATH 12-23-1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1906
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Wyatt		14. MOTHER'S MAIDEN NAME Effie Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT George York, Elkton, R.D.3. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593x Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-24-1958	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-24-58	
22c. NAME OF CEMETERY OR CREMATORY Daniel Cemetery		22d. LOCATION (City, town, or county) (State) Clay Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR North Cass Md	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		DATE DEC 29 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Death

Marion, W.B.

John

Marion, B.A.

Union Hospital, D.C.A.

Label

John

12-1-1900

12-1-1900

12-1-1900

Housewife

Marion, B.A.

W.B.A.

Marion, I. West

Marion, B.A.

George, John, Marion, B.A. W.B.A.

Acute Coronary Occlusion

Myocardial

R.O. Dutton

12-1-1900

Marion, I. West

Marion, B.A.

Marion, B.A.

12-1-1900